

# Exhibit B



**PO BOX 19072  
GREEN BAY WI 54307-9072  
Voice : 866-420-7455 Fax : 920-406-6537**

05/21/2018

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To **BRIANNA GALVEZ**  
Company **HILL & MOIN**  
Fax Number **12126686009**  
Voice Number **212-668-6000**

From **Customer Relations**  
Fax **920-406-6537**  
Voice **866-420-7455**  
Subject **prepaynotice**  
Order # **57422517**

Notes **Please see the following pre-payment notice**

This fax and any files transmitted with it are confidential and may contain information which is legally privileged or otherwise exempt from disclosure. They are intended solely for the use of the individual or entity to whom this fax is addressed. If you are not one of the named recipients or otherwise have reason to believe that you have received this fax in error, please immediately notify the sender and return or shred these documents immediately. Any other use, retention, dissemination, forwarding, printing, or copying of this email is strictly prohibited.

# PrePay Notice

**FIRST NOTICE**

Date Sent: 05/10/2018

**SECOND NOTICE**

Date Sent: 05/21/2018

**BRIANNA GALVEZ**  
**HILL & MOIN Acct: 500999**  
**2 WALL ST STE 301**  
**NEW YORK, NY 10005-2040**

Patient: **ELACHKAR, HOSSAM**  
SSN: \*\*\*-\*\*  
Claim/File #:  
Order #: **57422517**  
Fax #: **212-668-6009**

IMG

Records requested from: **NYU LUTHERAN MEDICAL CENTER**

Dear Requester:

IOD Incorporated has been retained by the medical facility listed above to provide release of information services. It is our policy to require payment prior to delivering the requested information. **Please note this is an estimated fee, the final amount may differ.**

|   |                                     |  |  |
|---|-------------------------------------|--|--|
| Service dates requested   | Specific Date(s): 1/19/18 TO 2/6/18 |  |  |
| Items requested   | Specific Items                      |  |  |
| "PERT ITEMS" = Dictated notes, radiology reports, lab reports, special test results, etc. |                                     |  |  |

| Description                           | Quantity | Unit Price                | Extension |
|---------------------------------------|----------|---------------------------|-----------|
| * Note: Hard Copy Page Count: 807     | 807      | \$0.00                    | \$0.00    |
| Copy Charge \$0.75 Per Page, Pages 1+ | 807      | \$0.75                    | \$605.25  |
| Shipping & Handling                   | 1        | \$0.00                    | \$0.00    |
| Sales Tax                             | 1        | \$0.00                    | \$0.00    |
| Pages as per Request:                 | 807      | Fee Quote as per Request: | \$ 605.25 |
| Notes:                                |          |                           |           |

The requested medical information will be provided after payment in full is received. Please make payment within 20 days of the first notice to avoid cancellation of your request. If the patient authorization has expired by the time payment is received, a new authorization will be required. Please note that it may take up to 15 business days from the date your request is received for your request to be processed. If you have any questions regarding this notice, please contact Customer Relations at 866-420-7455 \* Fax 920-406-6537.

- To make a payment online via credit card, go to [payportal.iodincorporated.com](http://payportal.iodincorporated.com)
- To make a payment via credit card, you can also call Customer Relations at 866-420-7455 Option 1.

To make a manual payment, please send this form and your check or money order made payable to IOD Incorporated to the address shown below. PLEASE DO NOT SEND CASH!

*IOD Incorporated TaxID No. 65-0765287  
PO Box 19072 Green Bay, WI 54307-9072  
Phone 866-420-7455 Option 1 \* Fax 920-406-6537*